MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1927

Do not use this space 10747

1. PLACE OF DEATH
County Vernon Registration District No. 875
Township Washington Primary Registration District No. 6163
City Nevada (No. ..... St. ..... Ward)

File No. .....
Registered No. 77

2. FULL NAME James Day
(a) Residence. No. Nevada St. 213 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. 6 mos. 18 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) ✓ 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (CITY OR TOWN) South Bend
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT none
(Address)

15. FILED 5/19 1927 E. R. Evans REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-3-7 1927

17. I HEREBY CERTIFY, That I attended deceased from 2-1-, 1927, to 3-7-, 1927
that I last saw h[illegible] alive on 2-36?, 1927, and that
death occurred, on the date stated above, at 3-36? 0 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) X
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Vernon Co Mo
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) L. O. Barrett, M. D
3/9, 1927 (Address) Nevada Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL State Hospital DATE OF BURIAL 3/10 1927

20. UNDERTAKER Turpin's ADDRESS Nevada Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Vernon
Township Washington
City (No. St. Ward)

Registration District No. 875 — File No. 78
Primary Registration District No. 6162 — Registered No. 78

2. FULL NAME James Day

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: M · 4. COLOR OR RACE: W · 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S	16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1937
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-29 1853	THE CAUSE OF DEATH* WAS AS FOLLOWS:
7. AGE: Years 74 · Months 6 · Days 8 · If LESS than 1 day, ... hrs. or ... min.	(duration) ... yrs. ... mos. ... ds.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work ... (b) General nature of industry, business, or establishment in which employed (or employer) ... (c) Name of employer	CONTRIBUTORY (SECONDARY) ... (duration) ... yrs. ... mos. ... ds.
9. BIRTHPLACE (CITY OR TOWN) ... (STATE OR COUNTRY)	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ... DID AN OPERATION PRECEDE DEATH? ... DATE OF ...
PARENTS 10. NAME OF FATHER	WAS THERE AN AUTOPSY? ...
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	WHAT TEST CONFIRMED DIAGNOSIS? ...
12. MAIDEN NAME OF MOTHER	(Signed) ... M. D. , 19 (Address)
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
14. INFORMANT ... (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL · DATE OF BURIAL 19
15. FILED 6/22 1927 E. R. King REGISTRAR	20. UNDERTAKER · ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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